IRO REVIEWER REPORT TEMPLATE -WC

INDEPENDENT REVIEWERS OF TEXAS, INC.

2150 S. Central Expressway · Suite 200-264 · McKinney, Texas 75070
Office 214-533-2864 Fax 214-380-5015
e-mail: independentreviewers@hotmail.com

Notice of Independent Review Decision

[Date notice sent to all parties]:

03/17/2015 and 04/08/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Left shoulder manipulation under anesthesia 23700

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified Orthopedic Surgery
Sub Specialty Orthopedic Sports Medicine

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is reported to be a male with a date of injury of xx/xx/xx. On 12/02/14, he was seen in physical therapy for his painful left shoulder with associated weakness following the surgery for a biceps tendon and large rotator cuff tear performed on 08/25/14. He was seen in physical therapy until 12/29/14 after having undergone 9 therapy sessions. He returned to therapy on 01/02/15 – 01/07/15. When he was seen on 02/17/15, he had limited range of motion in all planes.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

On 01/14/15, a utilization review adverse determination letter was submitted in which it was noted that manipulation under anesthesia for the shoulder is under study as an option in adhesive capsulitis and in cases that are refractory to conservative therapy lasting at least 3-6 months where range of motion remains significantly restricted manipulation may be considered. It was noted physical findings did not support a diagnosis of adhesive capsulitis and passive range of motion was 135 degrees and forward flexion at 125 degrees in abduction. On 01/29/15, a utilization review adverse determination letter was submitted again noting that manipulation under anesthesia for the shoulder is currently under study and physical therapy notes suggested abduction going to 125 degrees. Guidelines indicate there should be abduction of less than 90 degrees for this procedure and therefore the request was non-certified.

The Official Disability Guidelines indicate that shoulder manipulation under anesthesia is currently under study as an option in adhesive capsulitis. In cases that are refractory to conservative therapy lasting at least 3-6 months, where range of motion remains significantly restricted with abduction less than 90 degrees, manipulation under anesthesia may be considered. The last known note dated 02/17/15 notes restricted range of motion in all planes but does not objectify the range of motion deficits. The physical therapy note dated 12/29/14 indicates right shoulder passive range of motion was 160 degrees in flexion, 160 degrees in abduction, both greater than the left shoulder. Therefore, there is a lack of documentation of range of motion in abduction less than 90 degrees. In this reviewer's opinion, the requested right shoulder manipulation under anesthesia is not medically necessary and the prior denials are upheld.

IRO REVIEWER REPORT TEMPLATE -WC

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ **X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2013, shoulder chapter

Manipulation under anesthesia (MUA)

Under study as an option in adhesive capsulitis. In cases that are refractory to conservative therapy lasting at least 3-6 months where range-of-motion remains significantly restricted (abduction less than 90°), manipulation under anesthesia may be considered. There is some support for manipulation under anesthesia in adhesive capsulitis, based on consistent positive results from multiple studies, although these studies are not high quality. (Colorado, 1998) (Kivimaki, 2001) (Hamdan, 2003) Manipulation under anesthesia (MUA) for frozen shoulder may be an effective way of shortening the course of this apparently self-limiting disease and should be considered when conservative treatment has failed. MUA may be recommended as an option in primary frozen shoulder to restore early range of movement and to improve early function in this often protracted and frustrating condition. (Andersen, 1998) (Dodenhoff, 2000) (Cohen, 2000) (Othman, 2002) (Castellarin, 2004) Even though manipulation under anesthesia is effective in terms of joint mobilization, the method can cause iatrogenic intraarticular damage. (Loew, 2005) When performed by chiropractors, manipulation under anesthesia may not be allowed under a state's Medical Practice Act, since the regulations typically do not authorize a chiropractor to administer anesthesia and prohibit the use of any drug or medicine in the practice of chiropractic. (Sams, 2005) This case series concluded that MUA combined with early physical therapy alleviates pain and facilitates recovery of function in patients with frozen shoulder syndrome. (Ng, 2009) This study concluded that manipulation under anaesthesia is a very simple and noninvasive procedure for shortening the course of frozen shoulder, an apparently self-limiting disease, and can improve shoulder function and symptoms within a short period of time, but there was less improvement in post-surgery frozen shoulders. (Wang, 2007) Two

lower quality studies have recently provided some support for the procedure. In this study manipulation under suprascapular nerve block and intra-articular local anesthesia shortened the course of frozen shoulder (FS), although it is an apparently self-limiting disease. (Khan, 2009) In this study manipulation under anesthsia combined with arthroscopy was effective for primary frozen shoulder. (Sun, 2011) Frozen shoulder has a greater incidence, more severe course, and resistance to treatment in patients with diabetes mellitus compared with the general population, but outcomes for diabetic patients with frozen shoulder undergoing treatment with manipulation under general anaesthesia (MUA) are the same as patients without diabetes. (Jenkins, 2012) In this case series, treatment of frozen shoulder by MUA led to improvement in shoulder motion and function at a mean 23 years after the procedure. (Vastamäki, 2012) The latest UK Health Technology Assessment on management of frozen shoulder concludes that there was very little evidence available for MUA and most of the studies identified had limitations. The single adequate study found no evidence of benefit of MUA over home exercise alone. Generalizability is somewhat unclear because of the limited information about previous interventions that participants had received and stage of frozen shoulder. (Maund, 2012) The fastest improvement occurs following the first month after MUA, but 6 months after MUA, shoulder active range of motion remains lower than the uninvolved extremity. (Sokk, 2012) In this study, six months after MUA, endurance time and net impulse remained impaired for the involved shoulder. (Sokk, 2013) According to an Indian study, the efficacy of MUA, injection, and PT are comparable for adhesive capsulitis. (Ghosh, 2012) It is currently unclear as to whether there is a difference in the clinical effectiveness of an arthroscopic capsular release compared to MUA in patients with recalcitrant idiopathic adhesive capsulitis. The quality of evidence available is low and the data available demonstrate little benefit. A high quality study is required to definitively evaluate the relative benefits of these procedures. (Grant, 2013) See also Surgery for adhesive capsulitis. In other chapters, see the Low Back Chapter, where MUA is not recommended in the absence of vertebral fracture or dislocation; and the Knee Chapter, where MUA is recommended as an option for treatment of arthrofibrosis and/or after total knee arthroplasty, only after a trial (six weeks or more) of conservative treatment, and a single treatment session would then be recommended, not serial treatment sessions.